



## Upgraded Diagnostic and Treatment Center Background

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### Executive Summary

Upgraded Diagnostic and Treatment Centers were created in regulation in 1995 as a response to the closure of rural hospitals so that communities would have access to limited emergency services in a diagnostic and treatment center environment. There are currently no upgraded diagnostic and treatment centers in New York, nor are there similar models in other states except for the most remote and frontier. This paper discusses why Upgraded and Diagnostic Treatments were developed, the services they are allowed to provide, and a model used in Alaska for similar purposes.

### History

In the mid to late 1980's a specific focus on rural health care services began to be developed across the nation as a response to the closure of rural hospitals. One major initiative at the federal level was the creation of the Office of Rural Health Policy (ORHP) that would focus solely on rural health policy and programs within the Health Resources and Services Administration of the Department of Health and Human Services. In conjunction with community based programs, including Rural Health Outreach and Network, in 1991 the ORHP created the State Office of Rural Health program with the goal that there would be an office focused only on rural health issues in every state. The New York State Office of Rural Health was also created in Public Health Law in 1991. There are currently Offices in Rural Health in every state that receive approximately \$170,000 each to coordinate statewide rural health policy.

As the federal government began to review different models of care to respond to rural hospital closures, the New York State Office of Rural Health worked with the Rural Health Council to develop alternative types of providers to serve rural communities both through federal grants and state specific initiatives. Upgraded Diagnostic and Treatment Centers (UD&TCs) were part of that effort in NYS and were developed in conjunction with other models, including Critical Access Hospitals, to provide an option that would allow for the continuation of certain health care services, particularly emergency services, in a rural community if the local hospital closed. UD&TCs are a New York State specific model.

While the regulations for UD&TCs have been in existence since 1995, there are currently no facilities licensed as such nor have there been any establishment applications submitted. It is widely thought that there have been no UD&TC applications because there is not an adequate, defined reimbursement methodology. There was one site that

pursued designation and used a blended clinic and emergency department rate for financial modeling and found that it was not feasible. Reimbursing an UD&TC in the same manner as a diagnostic and treatment center is not sufficient because the capital and staffing costs are higher in an UD&TC if they opt to provide limited emergency services.

### **What is an Upgraded Diagnostic and Treatment Center?**

UD&TCs were codified in regulation in April 1995, Title 10, Section 752-2, and are defined as a general hospital that has relinquished its inpatient acute care bed capacity or an Article 28 diagnostic and treatment center that provides primary care services in a rural area. UD&TCs, whether previously a hospital or not, may also provide limited emergency services.

Specifically, a UD&TC must:

- possess a valid operating certificate and be in compliance with all other applicable state and federal requirements;
- participate in a rural health network defined as an affiliation of health care providers serving a rural area, pursuant to a contract or joint cooperative agreement, which may plan, coordinate, provide or arrange for the provision of health care services to residents of the rural area and/or the provision of administrative services among such health care providers.
- have a formal affiliation with a general hospital;
- be located in a rural area, defined as any county with less than two hundred thousand persons or any town which has a population of less than two hundred persons per square mile, or if approved by the commissioner, any town which has a population of less than two hundred fifty persons per square mile.

### **Optional Limited Emergency Services**

In addition to primary care services, UD&TCs may elect to provide limited emergency services on a 24-hour a day basis, seven days a week, within a network-wide emergency medical services (EMS) system as defined by a network operational plan or cooperative agreement. The UD&TC must ensure the availability of a 24-hour a day, continuous on-line communications link with its affiliated hospital(s) and other appropriate providers of emergency services, medical backup, consultation, inter-facility transport and medical control. Emergency services must be coordinated with other services of the UD&TC to facilitate continuity of care and discharge planning when post emergency needs do not require transfer to another facility.

UD&TCs that do not provide 24-hour a day on-site limited emergency services must ensure that patients in need of emergency care and arriving at the facility during non-operating hours are provided with information necessary to obtain emergency care.

The medical staff must be qualified to provide emergency services in accordance with patient needs and the service capabilities of the facility and must include at least one licensed physician and one or more currently licensed or registered health care practitioners including but not limited to registered physician's assistants and nurse practitioners.

It is important to note UD&TCs are not freestanding emergency departments or urgent care centers because they are to provide services within a coordinated system of care that includes a hospitals and other community based providers.

### **Perceived Benefits of Upgraded Diagnostic and Treatment Centers**

UD&TCs were developed to provide an alternative for communities that need health care services, including limited emergency care, but are not able to support a hospital. UD&TCs must provide services within a network so that continuity of care is ensured. It is also possible that UD&TCs would be able to alleviate pressure on local emergency squads, many of which are largely volunteer, that need to transport non-emergent patients out of the community to the nearest hospital. This causes the ambulance to be out of the community and unavailable for a true emergency.

### **Experience in Other States**

The Frontier Extended Stay Clinic (FESC) is one example of a model similar to UD&TCs. The Medicare Modernization Act of 2003 gave authority to the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration program to reimburse extended stay care received by Medicare beneficiaries at clinics located in remote and frontier communities. Additionally, the ORHP created a grant program in 2004 to work with 4 FESCs in Alaska and 1 in Washington.

A FESC is a clinic that is:

- located in a community where the closest short term acute care or critical access hospital is at least 75 miles away or is inaccessible by public road; and
- designed to address the needs of seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly or patients who need monitoring and observation for a limited period of time.

FESCs are allowed to keep patients for extended stays for more than 4 hours only if weather or other reasons prevent transport or the monitoring or observation is required for a short period of time. FESCs provide urgently needed care but are not permitted to:

- perform surgery except for those cases that may be performed in a physician's office;
- provide general or epidural anesthesia or deep sedation, or

- do planned delivery of newborn babies.

The CMS Demonstration Authority ends in 2013 and there is the possibility that the FESC model may be extended to all states. It is estimated that fewer than 10 clinics in the lower 48 states meet the location requirements

Evaluation findings have shown that the FESC model is financially feasible in Alaska due to lower transport costs for transfers and because clinics were able to be reimbursed for observation patients for whom they were already providing services. The FESC model may not be feasible in other states unless the location is very remote because of modifications and equipment purchases that are typically necessary to meet the program requirements.